BRANDY PASCHALL
MASSAGE & ESTHETICS

Therapeutic Massage Intake Form

Client Information:

Name: ____________________

Address: ____________________

Phone: ____________________ Email: ____________________

Emergency Contact Name: ____________________ Phone: ____________________

Occupation: ____________________ Referred by: ____________________

Health Information

Are you taking any medications? Yes No If yes, please list: ____________________

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) Yes No If yes, please list: ____________________

Are you pregnant? Yes No If yes, how any months: ______ Due Date: ____________________

Are you you currently under medical supervision or receiving other medical interventions? Yes No

If yes, please describe: ____________________

Areas of swelling
Autoimmune disorder
Back / neck
Bleeding disorders
Blood clots
Bruise easily
Cancer
Contagious condition
Decreased sensation
Diabetes
Fibromyalgia
Headaches
Heart condition
Hypertension
Kidney disease
Multiple sclerosis
Neurological condition
Neuropathy
Osteoarthritis
Osteoporosis
Phlebitis Sciatica
Seizures
Stroke Tendinitis
TMJ disorder
Varicose veins
Vertigo / dizziness

Areas of broken skin? (e.g. rash, wounds) Yes No How recently? ____________________

History of joint replacement surgery? Yes No Which joint(s)? ____________________

Recent injuries or medical procedures in the past 2 years? Yes No Please describe: ____________________

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Please describe any other injuries or health conditions: ____________________

____

Massage Information

Have you had professional massage before? Yes No How recently? ____________________

Reason for seeking massage: Relaxation Specific Problem

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How much pressure do you prefer? Light Medium Firm

By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge.

____________________ ____________________
Client(s) and/or Representative Date

____________________ ____________________
Therapist Signature Date

Please indicate any areas of discomfort